Strategies for Providing Culturally Responsive Psychiatric Care for Transgender, Nonbinary, and LGBTQ+ Patients

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FOCAL AREAS

- Background
- LGBTQ+ Mental Health Disparities
- Resilience Model
- Sources of Clinical Rupture
- Intersectional Model of Microaggressions
- Vignettes
- Intervention Strategies
- Resources
- Q&A
MENTAL HEALTH DISPARITIES AND MINORITY STRESS

- LGBTQ+ people experience a wide range of mental and physical health disparities (2).

- LGBTQ+ people often experience higher rates of homelessness, housing instability, intimate partner violence, and emotional abuse (12).

- LGBTQ+ folxs experience higher rates of minority stress related to social, institutional, and systemic forms of oppression (5).

- Trans+ people experience higher rates of gender-based victimization than cisgender peers; highest rates of suicidality of any group (2, 12).
Microaggressions during clinical encounters occur at higher rates than cisgender heterosexual patients \((1, 5, 6-8)\)

- QTPOC report increased negative clinical encounters \((3)\)

- Microaggressive experiences are often layered across levels of otherness \((6)\)
  - Identity concealment \((10)\)
  - Internalized homophobia \((9)\)
  - Sensitivity to rejection \((11)\)

- Numerous barriers to quality service provision and clinical care across treatment settings (e.g., emergency services, ambulatory care, primary care visits, specialized services, etc.) \((14)\)

- Patient-provider ruptures contribute to minority stress and trauma, adversely impacting patient mental health and well-being \((7)\)
AWARENESS OF INTERPERSONAL DYNAMICS IN SESSION

“Are you aware that when you said that your tail went between your legs?”
Figure 1. Transgender resilience intervention model (TRIM).
MICROAGGRESSIONS AND OTHER SOURCES OF CLINICAL RUPTURE

- Misgendering and deadnaming
- Assumptions about gender roles, presentation, or expression
- Invasive questions about patient’s body
- General lack of LGBTQ+ competency
- Conflation of psychiatric symptoms with Gender Dysphoria
- Gatekeeping vs. informed consent model
- Pathologizing sexual practices
CRITICAL AND INTERSECTIONAL MODEL OF LGBTQ MICROAGGRESSIONS (VACCARO & KOOB, 2019)

Figure 1. Critical and intersectional model of LGBTQ microaggressions.
EFFECTIVE INTERVENTION STRATEGIES

- Cultural humility and competency
  - Using resources developed by LGBTQ+ scholars
  - Consultation with area experts and stakeholders

- Fostering Inclusivity
  - Using LGBTQ+ inclusive terminology
  - Asking client for their names and pronouns

- Welcoming/inviting for identity disclosures
  - Encouraging discussions about patient’s identities

- Promoting culturally-responsive dialogue
  - Acknowledging impact of power differentials
  - Valuing patient’s perspective around isms
MISTAKES AND RUPTURES HAPPEN
ADDRESS AND INTERRUPT RUPTURES IN CLINICAL CARE

- Exploring and acknowledging the source of rupture
  - Naming it in session

- Helping the patient process their reactions to microaggressive encounters

- Extending invitations for repair
  - E.g., Seeking guidance around more affirming language, etc.
  - Valuing patient’s perspective
  - Intention vs. impact

- Corrective Experience
  - Making changes to foster inclusivity
IMPLICATIONS FOR CLINICAL PRACTICE

- Acknowledging role of biases and educational training in research and clinical practice

- Improve trans+ competency – specialized training for cisgender providers
  - Community-driven language
  - Diversity and nuance of gender presentations and identities
  - Integration of complex relationship styles and configurations
  - Implementation of non-pathologizing, decolonizing approaches
  - Centering intersectional perspectives

- Diverse and intersectional research teams to reduce cis-heteronormativity
RESOURCES

- APA Guidelines on Psychological Practice with Sexual Minority Persons (2021)
- World Professional Association for Transgender Health - Standards of Care V7 (2012)
- Affirmative Counseling and Psychological Practice With Transgender and Gender Nonconforming Clients (2017)
REFERENCES

Q&A